COUNTY OF PLACER
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Following is the Implementation Progress Report for Placer County's MHSA-Community Services and Supports Program in accordance with the State Department of Mental Health (DMH) Information Notice Number 08-08. This report covers the time period January – December 2007.

INTRODUCTION

Placer County continued to implement the Community Services and Supports (CSS) Plan in 2007 as part of the Campaign for Community Wellness efforts. The Campaign for Community Wellness is a unique-to-Placer initiative working to reduce stigma and increase awareness of mental illness. CSS is funded by Prop.63/Mental Health Services Act, a voter approved measure. For more information about the Campaign for Community Wellness please go to www.campaignforcommunitywellness.org

Woven into all CSS programs are the Campaign for Community Wellness and Propo63/MHSA Essential Elements as outlined below. We strive to provide services that are:

1) Cultural competent
2) Community collaboration-based
3) Client/Family centered
4) Recovery/ resilience/strength-based and wellness focused
5) Co-occurring competent
6) Focus on early intervention
7) Evidence-based and outcome focused
8) Part of an integrated service approach
9) Accessibility (to a wide range of people)

About Community Supports and Services

Community Supports and Services comprise the first generation of new Prop.63/MHSA programs and strategies being implemented. These programs and strategies are improving access to underserved populations, bringing recovery approaches to current systems and providing "whatever it takes" services to those most in need of critical mental health services. New program strategies offer integrated, recovery-oriented mental health treatment; case management and linkage to essential services; housing and vocational support; and self-help. We are proud to report that in our second year of implementing CSS services and approaches, more people are getting the services they need, in the way that they need them, and living lives at a much higher level.

Summary of Community Support and Services Progress Report
Seven components of the CSS programs will be included in this report as follows:

1. Rallying Around Families Together (RAFT) – a Full Service Partnership for children,
2. Placer Transition-Age Youth (PTAY) – A Full Service Partnership for transition-age youth (TAY),
3. Whatever It Takes (WIT) Team – A Full Service Partnership for adults,
4. Older adult Full Service Partnership,
5. Lake Tahoe System Development,
6. System Transformation (co-occurring, resiliency/recovery, cultural competency, and family/client driven system development strategies), and
7. Mental Health Crisis Response and Triage.

Great strides have been made in the development and implementation of all Full Service Partnerships (FSP), outreach and engagement and systems development projects. As is true throughout the State, most delays have been attributable to the difficulty in decreasing stigma and a slow adoption of the Campaign for Community Wellness/MHSA Essential Elements. Staff through training and leadership, are beginning to embrace cultural competency, recovery and wellness, client and family driven, and integrated/collaborative services. Additionally, staff are seeing the results of these new approaches with their consumers and this is providing the biggest incentive to change.

PROGRAM AND SERVICES IMPLEMENTATION

Following is a more detailed description of progress for each of the service categories. Transformational activities of community collaboration, cultural competence, client/family driven mental health system, wellness/recovery/resilience focus, and service integration are woven throughout all aspects of these new and enhanced programs.

Full Service Partnerships

As stated earlier, CSS was the first MHSA program to be implemented. In 2007, Placer received expansion funds for further CSS growth. Additionally Placer received a one-time allocation of new funds. Placer utilized the one-time allocation to provide services to those persons who were homeless and who had previously been served through the AB-2034 program. Persons eligible were enrolled in the FSP programs appropriate to their age. These one-time funds were used for services for the homeless with goals of transitioning them into housing and back into the community when possible. A majority of the expansion funds targeted services for persons who were involved or at risk of being involved with the criminal justice system. This identified population expanded services in FSP to better meet their needs. The service expansion was contracted through Placer's RFP process. Additional expansion dollars were used to create a small FSP in Tahoe with the proposed hiring of a case manager to serve 5 individuals in 2008.

Children's FSP

This FSP planned for and implemented High Fidelity (HIFI) Wraparound Services to families. HIFI is an Evidence Based Practice that speaks to Voice and Choice. Through CIMH seven statewide fidelity wraparound programs were initiated in 2007. Implementation in Placer enabled the Rallying Around Families Together (RAFT) team to increase their family caseload

capacity (by 140%) while improving quality of service resulting in high permanency outcomes. Some outcomes for the first of a 2-year implementation period are as follows:

a. A year ago RAFT had waiting lists; by the end of 2007, with the implementation of HIFI, there were no waiting lists and the team was carrying 14 cases in Auburn and 4 in Tahoe. 72 families were able to receive intensive services in the first year of HIFI implementation.
b. A challenge for this team is the ability to have paperwork in the native tongue of their clients (particularly in Tahoe). Resources exist in the county to have their paperwork translated into Spanish for 2008. Another complexity discovered in 2007, is that in the essence of "family centered practice" siblings often require services. The additional resources required and increased workload often goes unrecognized. It may look as though only one child is on a caseload, when in reality two to three others are also being served. Charting and case distribution by not only child served, but entire family distribution, will be considered for 2008.

Overview of TAY, Adult, and Older Adult FSP

This section will discuss improvements and successes for the TAY, Adult, and Older Adult Full Service Partnerships. Most impressively, these FSPs have successfully placed and maintained consumers in the least restrictive settings; the number of consumers in long-term placements decreased by 34% in 2007.

a. A MHSA FSP four-bedroom house was secured and offers a social program. This not only serves FSP consumer housing needs, but makes service delivery easier and increases the frequency of services offered.
b. A 24/7 phone line was implemented to provide coverage for FSP consumers. This improved consumer care by having a FSP team member easily accessed by consumers, partnering agencies, and other county teams. Therefore, more successful integration of services was achieved.
c. Eleven FSP staff were trained at "The Village". This immersion training allowed our staff to see an example of successful recovery based services. Staff came back excited about the MHSA essential elements. This was reflected in more recovery oriented service/treatment plans and service delivery activities.
d. Placer put out a RFP and implemented a contract for a Board and Care facility, Harmony House, on the De Witt Campus in Auburn serving 15 clients, eight of which are adult FSP consumers who have previously been un- or under-served. The close proximity to county facilities, including the Welcome Center, has allowed greater collaboration and more seamless services. County staff aid with providing on site nursing, psychiatric, and case management services.
e. Due to the high need for additional FSP slots, CSS expansion funds will be utilized in 2008 to award, through a RFP process, a contract to serve 30 additional FSP psychiatrically disabled individuals involved in criminal justice.
f. Placer plans to hire a Family Advocate in early 2008. The position will work half-time with the FSPs and half-time with Crisis Triage. The role of this position will include orienting clients to our system, leading support groups, and providing advocacy and navigation services to consumers and their family members.

Transition Age Youth FSP

The goal is to provide services to targeted TAY and young adults who were un- or under-served. The team receives referrals primarily from Children's System of Care (CSOC) and has been transitioning 16 and 17-year-old children from wraparound to TAY services. In addition, referrals are accepted from the community. All referrals are assessed for level of treatment needed. Placer developed a TAY level I and II system.

In TAY level I, the focus is on outreach, brief services and accessing community resources for housing, education, and vocational needs. In 2007, the team has successfully developed outreach strategies to increase referrals from community partners. Outreach and brief services were provided to 275 people to assist them in utilizing community resources.

TAY Level II services are children who are determined to be most at risk, due to serious mental illness and a history of hospitalization, out-of-home placement, co-occurring substance abuse, or incarceration and are referred for intensive case management services. They served their target goal of 22 clients, 3 of who were previously AB-2034 homeless clients. They hired a FSP Youth Employee and presented on a panel at the CIMH MHSA Small County Conference.

Challenges include balancing the consumer's desire for independence with their often lack of resources such as job skills, housing, and family support. These difficulties are frequently compounded by substance abuse. In 2007 efforts were made to work with this challenge by collaborating and developing plans with other county divisions/teams for consumer placement, housing, co-occurring engagement strategies, and skill development. Integration and collaboration will be a continued effort for 2008.

In relation to housing, THP-Plus funding provided housing for 20 TAY in 07-08 and Placer has requested capacity for 40 in 08-09. Other strategies for providing even better services to consumers include developing a comprehensive triage/screening for TAY referrals from CSOC, building continued integration/communication pathways between county teams, and expanding independent housing opportunities for TAY consumers.

The Youth Transition Action Team was established (late in 2007) to increase collaboration and incorporate "Youth Voice" into MHSA programming. Youth meet to provide support for other "aging out" youth and provide input to policy and programming to promote recovery and reduce stigma. It has been difficult to engage youth into advocacy and leadership roles.

Adult FSP

Following the model of recovery and resiliency, the target population is adults who have been living in locked residential settings or those with frequent hospitalizations. Reaching staffing goals in 2007 allowed the Adult FSP to begin to see even greater outcomes. The outcomes are as follows:

a. Reduction in use of IMDs by 45% in a 2-year period (06-07).
b. Expanded population to incorporate AB-2034 clients. Instead of the target of 24 FSP clients, 81 individuals were served by the FSP in 2007.
c. Marketing materials were created and distributed to county teams and community providers via staff presentations, consumer stories, and by the

Campaign for Community Wellness whose marketing efforts use the web and newsletters to reach a large audience.

d. Increased collaboration and more seamless utilization of the 24-hour crisis response and a crisis residential facility, Rosewood, has been instrumental in reducing the need for psychiatric hospitalization.

Difficulties for the adult FSP has been obtaining consistent nursing support for the team, developing plans/integration with other teams for consumer placement, and working with housing issues and needs for independent living arrangements. Surprisingly, the FSP house was underutilized due to clients desire to live alone. The FSP team found that single room occupancy (a hotel in downtown Roseville) better fit for many of the consumers' needs. Housing opportunities for consumers will continue to be explored in the planning and development of the MHSA housing component. Recommendations to the MHSA Workforce Development planning team will be made regarding the need for more nursing support.

Older Adult FSP

The goal is to provide services to older adults who have been historically un- or underserved through intensive case management.

a. The team developed outreach services to address older adult referrals.
b. Staff made 12 presentations marketing and describing the Older Adult FSP program.

The older adult FSP receives input and direction from the Older Adult Commission (OAC) that meets monthly. During 2007 the OAC conducted a survey of over 1000 seniors to better identify their needs. In spite of significant outreach and engagement activities the older adult FSP was serving five of the targeted 25 consumers by the end of 2007. Given the underutilization, and the over utilization of the Adult FSP, it appears there may be a greater need for adult slots than older adult slots for this intensive service model.
Recruitment efforts from the geriatric programs at CSUS resulted in bringing on an intern who has gerontology as her specialty major.

Further outreach for hiring older adults into employment and recruiting more nursing and geriatric specialty staff is needed. Better integration and communication with other county teams is also needed.

System Development and Transformation

With the expansion money in 2007 Placer chose to focus on promoting consumer voice and reducing stigma by hiring more consumer Navigator positions throughout Adult System of Care (ASOC). A practitioner was added at the end of 2007 to the Crisis Response to assist with the high volume of individuals needing urgent services and to develop resources and supports for family members and significant others. The need to bring a Family Advocate to ASOC was also identified and preparation began in 2007. Supports and structures have been put in place to increase peer and family lead recovery activities, to enhance cultural competency, and to train staff on collaborative, evidence-based-practices, which embrace the concepts of recovery and resiliency.

Consumer Voice

More consumer involvement has created a powerful difference in service delivery. In 2007 15 Consumer Navigator's were hired which brought Placer up to 18 (identified) consumer employees working in client service delivery. At the end of 2007, four were awaiting placement, which speaks to the interest in the program by Navigators. Consumer employees and volunteers attend committees, participate in staff meetings, and are influencing the culture. People think and talk more in recovery minded words with consumers and family members working side-by-side. Challenges to this program are existing stigma, misconceptions about dual-relationships, and providing sufficient support to Navigators and employees (around the program). The program would like to expand Navigator's roles and possibly provide more support for those who would like to advance in the mental health field. Further support and training for both Navigator's and staff around Recovery Principles related to consumer employment would be beneficial. Hopefully funding from WET will assist with training and incentives for career advancement for consumers and family members in the future.

Another important component in establishing consumer voice is the Listening Well program. Placer sent 35 consumer staff and mental health clients to develop and share "their story". The story often begins with a story of trauma and isolation and grows into their story of recovery. Some agree to share their stories at community and county events. Over 15 consumer stories were shared at varying events and publications in 2007. Stories not only aid individuals in recovery they assist in decreasing stigma and in educating the community. The consumer voice was utilized in the Campaign for Community Wellness Steering Committee and staff meetings to further the understanding of recovery and to reduce stigma.

Placer's Consumer Council was established and grew to 15 active members in 2007. They are consulted monthly by policy making teams for their input. Main areas of focus are housing, stigma, transportation, employment, and improved mental health services. A challenge has been getting consumers to drive this process with less staff leadership. A goal for 2008 is to have consumer leadership emerge.

We also have ten Family Advocate staff on teams as paraprofessionals, advocates, and experts on "lived experience". They attend staff meetings to be a family voice. They are working to expand their roles as paraprofessionals, be accepted by employee peers as having useful knowledge of our mental health system, and receiving additional training. An identified need is for a Family Advocate to work in Adult System of Care in 2008. We also had three youth mentors to fulfill similar roles with the children's and TAY population.

Welcome Center

The Welcome Center (consumer drop in center) housed on the DeWitt Campus in Auburn, greatly expanded in 2007 by adding over 10 activities/services to their calendar. This is Placer's most notable example of client driven services. Consumers are the driving force of activity planning, services offered, and more. In 2007 they averaged 35 consumer participants a day. Other highlights include: expanded services to Roseville, providing a van ride from Roseville to Auburn one day a week, increasing the hours of operation to 5 days a week -4 hours per day, providing services by appointment from 8am-6pm, adding 2 consumer run support groups and Art programs, creating binders and bulletin boards with job, housing and resource information (updated weekly) in Auburn and Roseville, providing budgeting and

resume software on 4 computers, SSI Advocate available weekly by appointment, presentation by partner programs, field trips, fundraising, and more.

Consumers from the Welcome Center sit on Placer Consortium on Homelessness, the Mental Health Alcohol and Drug Board, MHSA Steering Committee, and attend community meetings for housing elements and strategic planning. Consumers attended conferences, the California Network of Clients annual Client Forum and trainings on cultural competency.

Challenges are: transportation to the Auburn site, continued need for additional services in Roseville, maintaining the most useful resources/programs for the ever-changing population, and the cost of maintaining programs. It is hoped that in 2008 resources will facilitate an increase in self-help activities in Roseville, increase overall participation and activities, work with Consumer Council to create a strategic plan for the Welcome Center, increase financial self-sufficiency, and increase the number of Listening Well Facilitators in order to offer the experience as a weekly group in both Auburn and Roseville without need for external contractors.

Co-occurring Substance Abuse

Special attention is being paid to improve the treatment outcomes for those with co-occurring disorders. Dr.'s Minkoff and Cline have provided training and consultation to the staff and management of CSOC and ASOC, as well as, community partners to improve access, engagement and treatment strategies for those with co-occurring disorders (COD) with emphasis on working more collaboratively in an integrated service model. The Change Agents and Co-Occurring Project Management Team (COD PMT) have specifically been tasked to work on achieving these goals.

Approximately 40 “COD Change Agents” (a collaborative group comprised of HHS, and numerous community partner agencies, including our alcohol and drug treatment providers), formed into a solid group in 2007. They identified missing stakeholders and invited them to participate. They developed leadership from among the group as well as assigned a supervisor to provide feedback and communication to the management team. They created a vision and mission that compliments the COD PMT charter. The Change Agents influence practice at all levels of the organization and make recommendations to the COD PMT regarding policy and procedure. The Change Agents had three meetings with Minkoff and Cline to learn about their role/function as well as receive additional co-occurring competence training. They also met twice on their own, to continue group formation. They developed a marketing committee (to put items in varying Newsletters) and are considering the formation of other committees in 2008.

COD PMT developed a charter and began work on a “work plan”. They meet monthly to discuss outcomes from the Compass (a tool to assess teams), weaknesses and strengths around co-occurring competence in Placer County, and barriers to co-occurring treatment. Challenges to obtaining an accurate count of “co-occurring” clients include: Medi-Cal requiring a primary diagnosis, funding streams, staff awareness of co-occurring, and assessment/treatment tool limitations. COD PMT will work to educate and obtain a more accurate count, increase awareness, and recommend welcoming and integration practices to improve treatment in our system.

A challenge has been overcoming staff notions that they are already functioning in a co-occurring capable manner and getting change agents to understand their role. Many struggled to feel they can make a difference in the organization. Also, determining the relationship between COD PMT and the Change Agents was challenging at first. Change Agents were tasked to challenge the traditional top-down informational flow and understanding the relational information exchange between these two groups was difficult. Now that the Change Agents feel empowered in their role to transform the system, in 2008 the goal is to invite Supervisor's to support the initiative and allow for more communication back to the various teams. They would also like to develop more committees and tasks for the change agents aimed at integration of services, co-occurring and welcoming strategies. Change Agents and COD PMT hope for more involvement from CSOC in the future to fully integrate our system. Change Agents will continue to report suggestions for better services to the COD PMT. COD PMT will continue to develop a work plan and influence integration of services at a management level.

Crisis Triage

Prior to October 1, 2007, CSOC was responsible to provide emergency response for both Adult and Children (ACCESS) in Placer. As of October 1 Mental Health and social service emergency response has been redesigned to direct Children's emergencies to CSOC and Adult emergencies to ASOC. This enabled ASOC to provide care to any adult needing mental health services from the point of first contact. It also allows easier and more immediate entry into ASOC. The time from first phone call to assessment reduced from two weeks to eight days for a non-urgent request. Within 1-2 working days following first phone call, the individual now receives a phone call from a practitioner, initial assistance, and screening in a timelier manner.

To better collaborate with our community, all crisis services have been physically relocated to the Sutter Roseville Hospital and staff respond directly as needed to the hospitals in Lake Tahoe and Auburn. Approximately 2000 individuals were evaluated and received crisis intervention at hospital sites.

For individuals who do not meet the criteria to enter ASOC services, they are immediately referred to the new, MHSA funded, "Same Day, Next Day" (SDND) team for intensive crisis resolution services. In 2007, 628 individuals received SDND and crisis treatment response services, so that no one in crisis would fall through the cracks. A block of urgent appointment times with a psychiatrist was established to ensure that consumers in crisis would receive the care they need to avoid hospitalization.

In late 2007 with CSS expansion funds, a practitioner was hired to assist with the high volume of individuals and to lead family and consumer groups. In 2008 a Family Advocate will join the crisis team to co-lead the family group and provide support to families. This will allow an employee with "lived experience" immediate contact with family members to help better understand or navigate the system.

Lake Tahoe System Development

Lake Tahoe Mental Health services are provided through a contract with Sierra Family Services (SFS). SFS over the course of the past couple of years has additional bilingual staff. Currently SFS has 2 bi-lingual therapists and added a bilingual Community Educator at the end of 2007. 44 mono-lingual Spanish speaking individuals received services in 2007. The prior wait list was eliminated with the additional bilingual staff. Additionally 59 people received outreach, engagement, and assistance in collaboration with Family Resource Centers and other community resources. In 2007, Tahoe was identified for additional CSS funding to hire a case manager to provide intensive community services to 5-8 individuals psychiatrically disabled adults at greatest risk of hospitalization, frequent crisis contact, homelessness, or incarceration. It is anticipated a case manager will be hired in 2008.

In 2007, 4 staff went to trainings in cultural competency. Also, the bilingual/bicultural therapist has regularly attended the family support team meetings and has regularly participated in supervision meetings to instruct the team in cultural competency. The program manager participated in the MHSA Campaign for Community Wellness meetings. This helps ensure better communication and service identification to an area that is distant and historically underrepresented in the planning process.

All Tahoe staff have responded to questions from our partnering agencies and are participating in family team meetings with Latino families. Out of recommendations from bi-cultural staff and Latino clients, staff has made it a priority to meet with clients in locations that best meet the client's needs. Meetings occur at the office, schools, and Family Resource Centers (FRC). Mental health trainings have been given to our partnering agencies, focusing on cultural aspects. SFS Tahoe has become more focused on the varieties of cultures and is appropriately becoming more aware and welcoming.

There have been demographic collection forms developed and implemented in the past year for our MHSA clients. Advocates at the FRC received training and supervision from our therapists. Community partners were involved in the hiring of the Community Educator. As a result, referrals have increased from our partnering agencies including Tahoe Women's Services, FRC, and CSOC. We are serving a larger demographic in a more culturally competent and welcoming manner.

Challenges for 2007 included finding appropriate bilingual staff and having key county and other partnering agency staff leave, requiring new relationships to be built. Needing to meet and comply with Medi-cal standards makes it difficult to be culturally competent in allowing people to tell their story yet ensure all required Medi-cal elements are captured.

Cultural Competency

The Native Network was established and created a planning and advisory group made up of Native organizations, Tribal Elders, Native community members, and SOC staff. This collaborative is guiding the development of services and supports for the Native community. A Latino Leadership Council was established, this group is a planning and advisory group made up of Latino(a) business professionals, Mental Health and social services professionals, community leaders, and service providers.

The Cultural Competency Committee hosted a regional Tribal STAR (Successful Transitions for Adult Readiness) training called "Making Connections". Seven CSOC staff, Native Elders, and community members attended this two-day train-the-trainer event. The training uses a multicultural model to create healing within and between the Native community and the Anglo-European community. Placer also hosted several Cultural Competency trainings by Dr. Matthew Mock for SOC and Partner Agency Leadership and Management staff. All staff will attend this training in 2008.

Family Advocate Program Director, Diane Shively, moved forward in creating an independent organization for youth and family members. She applied for and was awarded 501(C) 3 tax exempt status for the Placer Family and Youth Network. CSOC through a contract with United Advocates for Children and Families hired a full-time Youth Coordinator and Youth Mentor. The Youth Coordinator and two Youth Mentors will begin to form a youth group, "The Placer Youth Voice" and are in the process of mobilizing youth to become involved. Collaboration with Sierra College, Whole Person Learning, ASOC, CSOC, and Foster Youth Services was also established to better meet the needs of youth transitioning to college.

Placer County has continued to provide training for SOC staff to better understand "Client Culture" and the process of engagement and recovery.

Difficulties include overcoming trust issues, building relationships, and expanding flexibility in the county system to allow for cultural differences. We continue to struggle to have a large group of consumer and family representation to ensure diversity of the voice and reduce a risk of "tokenism." We need to develop authenticity in a way that true transformation can occur. Also, transportation continues to be a barrier for involvement.

Continued outreach to Latino, Native communities, and TAY is needed and being planned. Ways to support and hire more bi-lingual/bi-cultural staff is being explored (particularly in Tahoe area). More youth involvement and staff hires are recommended. Plans are in place to begin implementing more supported housing opportunities for TAY through THP Plus grant. Follow-up is needed to incorporate recommendations from the Native Network and Latino Council identified in the Community Readiness Assessment to better address disparity in Access to Mental Health care.

Improving access to Physical Health Care; ASOC in collaboration with Placer Community Clinic share a Nurse Practitioner who has extensive Psychiatric experience. ASOC provides psychiatric consultation and clinical supervision to this Nurse Practitioner. This shared position has: 1) increased ASOC clients ability to access health care 2) increased communication and integration of services between mental health and physical health care 3) aided in developing a smoother transition for the individual to receive their on-going psychiatric medications from their physical health care provider once they are no longer needing mental health specialty service.

IMPACT OF SYSTEM DEVELOPMENT ON THE MENTAL HEALTH SERVICE SYSTEM

System Development has been transforming our system in a truly "developmental" way. Step by step changes to our organization and staff practices are being evidenced. Leadership staff were trained in Cultural Competency which has led to many cultural awareness conversations.

Navigators, hired in 2007 are working side by side with staff and changing the way we discuss cases and encourage client success. The co-occurring "Change Agent" movement has not only helped Mental Health staff learn more about Alcohol and Other Drug (AOD) and vice versa, but has given staff an empowering model to influence system integration change at a "grass roots" level. Our entry team's ability to better navigate newcomers to the right level of care and provide a support system for those not entering our system has greatly improved services. Clients are being seen sooner and are given more support to integrate into their community. Overall, our system is changing, staff attitudes and beliefs about Recovery are improving, and consumer involvement and outcomes are increasing. We expect this change to continue into 2008 and take us to our next developmental stage of Recovery.

Efforts to Address Disparities

OUTREACH AND ENGAGEMENT

Placer County's Plan identified youth and adults who were incarcerated, in out-of-home or locked residential placement, or who had frequent hospitalizations, as well as communities which have been historically underserved such as Native Americans, Latinos, TAY and Spanish speaking individuals living in the greater Lake Tahoe area. Please see each separate team report for specifics on team outreach and engagement. This section will highlight some teams and give overview to other efforts.

Enhanced Interagency Collaboration

MHSA oversight has been folded into existing interagency structures wherever possible. The long standing SMART Management Team (SMT) oversees the activities of the Children's and TAY FSP's. The Transition Review Team (TRT) is a sub committee of SMT to review TAY referrals for either Level I or II services and to provide guidance to improve services and integrate resources specific to the needs of the TAY population. The Transition Review Interdisciplinary Team (TRT) is comprised of managers of contracted non-profits, CSOC, and our Family Advocate staff. This group provides oversight and accountability to the TAY team. Currently, TRT is refining the referral process for aging out children. A Youth Transition Action Team, which includes both youth and agency providers, meets once per month. The purpose of this meeting is for information sharing and program development in the areas of housing, education, and employment.

An interagency Older Adult Collaborative has been in existence for several years in Placer County. It will provide oversight for MHSA activities and guidance to assist with outreach, engagement and integrate community resources to better serve older adults. In addition, the Collaborative has been actively providing input and suggestions regarding recruitment challenges. One outcome is that the older adult FSP will be transitioned to integrate into other older adult services, including: IHSS and Public Guardian. The older adult FSP team will consist of a half-time nurse, one clinician, one case manager, and half of a supervisor in 2008.

With regard to targeting persons currently residing in locked residential facilities, Placer County has had tremendous success in its efforts toward community re-integration. Nearly all of the 22 Adult FSP were residing in an IMD or had frequent hospitalizations. An "Adult Reintegration Team (ART)" works closely with the FSPs and help individuals develop a plan

for community integration. The effort to get consumers re-integrated into the community has been very successful despite three significant barriers: 1) the need for more local housing alternatives, 2) the unwillingness of local board and care facilities to take individuals with co-occurring medical problems such as diabetes, and 3) the difficulty of an already over-burdened Mental Health out-patient program to take on more clients as the FSP's have filled. Since housing is a critical component of the ability to bring consumers home, efforts are underway to increase the number of housing alternatives, such as the opening of Harmony House, a board and care, on July 27th, 2007.

The Consumer Council is a place for consumers to participate in county development. Consumer Navigator's help create a welcoming environment that is easier for consumer's to navigate, therefore increasing outreach. The Welcome Center has provided a safe and peer friendly environment for outreach and engagement of many consumers including homeless mentally ill individuals Self help groups, art and leisure classes, outings, job/housing resources, etc. invite consumers from in and out of the system. The holiday parties bring in over 100 consumers and each time new visitors attend. The consumers at the Welcome Center also publish a newsletter which is both mailed to consumers and made available at the Center. This serves as a mechanism to keep consumers informed of new services, activities, and opportunities for recovery.

Several Newsletters have been established to keep the public and various organizations informed: ASOC, CSOC, and the Campaign for Community Wellness began producing Newsletters that highlight changes and growth. The Campaign newsletter is distributed to over 1500 people/organizations on Placer County Network (PCN) (a large e-mail distribution list), the Campaign roster, and on Placer County's website. The Campaign for Community Wellness also has a web site that readily informs the public of the steering committees activities, meeting minutes, and upcoming community events.

Native American and Latino Outreach

Particular attention is being paid to outreach into the Latino and Native American communities to identify children and families who have not been adequately served. After collaboration with community leaders and the schools, a Native Network became stronger and a Latino Leadership council was established in 2007.

The Native Network and Latino Leadership completed a community readiness assessment to identify strategic planning priorities. Placer's overall score was a 3 "Vague Awareness". Recommendations to increase our community score include: training, recruitment, community education, resource development, and better communication styles with various cultural groups. Detailed suggestions were presented to the Campaign for Community Wellness Steering Committee.

Native Network

Completed Placer County Native community services inventory and gaps analysis, held two strategic planning sessions with the Native Network, gathered key informant interviews with elders/leaders, identified secondary data to confirm community needs and disparities as outlined in the CRA, and identified evidence based practice for Native Youth and the larger cultural group. This information will be incorporated in future MHSA components including

Prevention and Early Intervention planning. A representative from the Native Network is a voting member on The Campaign for Community Wellness Steering Committee.

Recommendations for service improvement to the Native community include bringing examples of cultural "best practice" to the county setting (e.g. "Talk Drum"). Suggestions were made that the County culture may need to expand its structure to allow for Native "best practice" activities. Community based organizations should continue to be supported in delivering services to the Native American community as this is the preferred setting. Further collaboration with government, community based organizations, and non-Native resources will continue to help break barriers. Lastly, cultural-based practice versus current evidence-based practice should used with the Native community.

Latino Leadership Council

Was formed and actively began participating in the following meetings: Cultural competency committee, monthly Campaign for Community Wellness Steering Committee, social marketing, and SAMHSA Steering Committee. They also began gathering information and input to build a plan for Prevention and Early-Intervention strategies for Latinos. They also facilitated six monthly meetings with LLC members (SAMHSA) to gather input and priorities, coordinated and facilitated meetings among Lincoln community members to assess MHSA needs for Latino populations.

Per the above efforts, the Latino Leadership Council identified the following needs for their community: reduced stigma around seeking mental health supports, particularly with undocumented immigrants. There is a lack of bi-lingual/ bi-cultural professionals to serve community needs, and a lack of resources to increase these areas. Recommendations are for more collaboration with faith based, county, and community organizations and increased support to Latino/a staff to advance in the system, allowing them to create more culturally competent services.

Funding to Native American Organizations

The Native Network has not received direct funding; however, they are represented and directly involved in planning for Prevention and Early Intervention strategies specific to Native needs. At the recommendation of the Native Network, a Native liaison was hired on contract to provide guidance on issues pertaining to cultural competence and service delivery. We expect growth in this area in 2008 due to increased staff and leadership capacity.

Policy/System Improvements to Reduce Disparities in Requests for Proposals, Contracts

The Request for Proposal (RFP) written in 2007 was written with the MHSA transformational goals in mind. The MHSA essential elements were written into contracts, requiring proposers to address ways they would continue the transformational process. Specifically, our RFP language speaks to client driven, culturally competent, recovery/resiliency oriented, and co-occurring capable services. There was a special emphasis on outreach to the Hispanic Community. County contracts contain language-prohibiting discrimination on the basis race, ethnicity, gender, age, religion, or sexual preference either in hiring or in service delivery.
Additionally, in regards to culturally competent documents, Placer County has made an effort to not only translate documents into native tongues, but review documents in a culturally

sensitive manner. Medi-Cal requirements at times pose a barrier however Placer will continue to strive for improvement of in obtaining needed information in a culturally relevant manner.

STAKEHOLDER INVOLVEMENT

Campaign for Community Wellness

In an effort to coordinate and leverage key mental health initiatives and ultimately, improve mental health care in Placer County for all people, the Campaign for Community Wellness was created in the Fall of 2006. In 2007, the following goals were developed: 1) Improved and cost-effective mental health services, 2) more consumers on the road to recovery, 3) people with mental health issues and their families feel heard and empowered, 4) all people that need services are reached: children, transition-age youth, Latinos, Native Americans, adults and older adults, and 4) all services be provided in a welcoming, co-occurring and culturally competent manner.

In 2007, the Campaign for Community Wellness efforts accomplished:

- 11 Steering Committee Meetings with increased participation from consumer and family, Latino, and Native American voices and the public attending due to publications in the newspapers.
- A newsletter that includes consumer participation that is sent quarterly
- Website expansion
- Expansion of System Transformation
- Cultural Competency Trainings
- Community events that increase public awareness of mental illness and recovery

Led by a Steering Committee of over 35 community members, advocates, providers, consumers and family members, the Campaign for Community Wellness is working to coordinate and implement the Mental Health Services Act (MHSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) programs in Placer County.

Other Stakeholder Groups

Consumers, family members, and other stakeholders have been involved in the short-term and long-term planning and day-to-day operations of Placer County's system transformation. Since the approval of Placer County's Plan in February 2006, continual updates have been provided to various groups of stakeholders.

Throughout 2007, stakeholder meetings (e.g. Campaign for Community Wellness Steering Committee, Mental Health Drug and Alcohol Board, Consumer Council, and Family and Youth Advocates), as well as individual team meetings have included consumer and family member stories of recovery/resilience and cultural experiences. This has helped set the tone for participation in a transformational process.

The Mental Health, Drug and Alcohol Advisory Board meet monthly and, by statute, has a membership comprised of over 50% of its members as consumers or family members of

consumers. They have been advised of MHSA implementation activities at each meeting and they review and approve every contract for service proposed by the division.

The Consumer Council is another important stakeholder, members of the council attend the Campaign for Community Wellness Steering Committee and report back, also every stakeholder process includes gathering input from this group. They provide input to planning process and county policy and procedure through verbal focus groups and surveys.

Consumer Navigators are paid employees in ASOC who transform our system by being part of the teams and service delivery. Family members and youth have been actively involved in the development of recovery and resiliency based programs. Family Advocates and Youth Mentors have been contracted by the County to provide assistance to individuals and families involved in the system.

Improving cultural competency has also necessitated on-going involvement of the Native American and Latino communities in the planning process. An outcome of collaborative planning with community leaders and the schools was the formation of the Native Network and Latino Leadership Council. These groups are sought for input on various planning efforts. They provide excellent input and have given feedback that seeing their input utilized is essential to continued stakeholder relationships.

Stakeholders also include the many service providers in Placer County who are part of the continuum of care. Some of these groups have already been mentioned – the Older Adult Collaborative, Placer Collaborative Network, and Tahoe Truckee Community Collaborative. The members represent geographic areas and cultural diversity. Staff from the MHSA programs serve on all of these committees and regularly provide updates, answer questions, and seek input from the attending members. Mental Health providers in the community were invited to participate in several of the training opportunities on recovery and treatment of co-occurring disorders.

In early 2007, numerous newspaper stories and well-attended public kick-off events, helped to "get the word out" to stakeholders and made the process simple and easy to engage and be informed on. Web-based sources of information offer yet another medium for persons to access information, respond, and get involved with MHSA and other system transformational activities.

PUBLIC REVIEW AND HEARING

This report was posted for a 30-day public comment and review period. A Public Hearing was conducted by Placer County's Mental Health, Alcohol and Drug Board on June 23, 2008 at Health and Human Services Adult System of Care Administration Large Conference room 11533 C Ave., Auburn, CA 95603 from 6:00-8:00 P.M..

During the Public Hearing, a representative of NAMI Placer County submitted in writing (attached) and expressed her concerns regarding the MHSA 2007 Implementation Progress Report.

Local Mental Health Alcohol and Drug Board that conducted the Public Hearing reviewed and approved the following response to the Public Comment during the subsequent Local Mental Health Alcohol and Drug Board meeting of July 18, 2008.

1. The report should state where the report was posted.

   Answer: Placer will include the web address of the posted report in the future. The web page was included in the press release as http://www.campaignforcommunitywellness.org however it will be included in the report in the future. In addition, it will state where a hard copy can be found. Hard copies were placed in the Welcome Center and the Mental Health Clinic offices. The library is an excellent suggestion and we will put a hard copy at the library in the future.

2. NAMI is concerned that the county provide better services to clients who are not in long term care but are existing clients.

   Answer: Placer is concerned about the welfare of all clients especially with current service reductions. Placer is working hard to develop alternative support services for all clients who need them.

3. Question: Was MHSA money used to secure the 4 bedroom house or to support the program only for FSP?

   Answer: The house referenced was funded with MHSA dollars so that FSP clients could be housed and receive appropriate services.

4. The use of acronyms (like RFP) is confusing

   Answer: Placer will spell out all acronyms in the future

5. NAMI was pleased that 30 additional consumers involved with the criminal justice center would be served.

   Answer: Thank you for your support.

6. The Welcome Center is believed to see at most about 35 clients a day. At one time the Mental Health Alcohol and Drug Board was told it was 50 a day.

   Answer: Placer agrees that the average attendance at the Welcome Center is 35 persons a day. However, this number varies depending on the quarter (in the first quarter of 2007 the exact average for the quarter was 49).

7. NAMI is confused about the number of persons assessed for 5150 in the County as the 2007 annual update states 2000 and a report to the MHADB reported 1005.

Answer: The report to the MHADB was for FY 06-07. The total number of persons assessed for 5150 throughout the county was 1839. The total number assessed for 5150 at Sutter Hospital was 1005 which was 54.6% of the total.

8. NAMI does not believe the PIP report stating that the wait time for a doctor appointment went from 12-14 weeks to 8 days.

   Answer: NAMI is correct the time waiting for a clinical assessment went from 29 days to 8 days. The wait time from the assessment to see a doctor was reduced from 70 to 47 days.

9. NAMI has asked to see an update of the current status of clients in Cypress House.

   Answer: Two reports were given to the MHADB on the clients who were discharged from Cypress House at the time of its closure. One report reviewed the client status at 6 months and one at 12 months after the closure.

10. NAMI would like to see the financial breakdowns of the money being spent in MHSA

    Answer: The MHSA cost report is now complete for FY 06-07. The cost report is the official county document that is reported to the state that identified both revenue and expenditures for all mental health programs. County has standard accounting practices that require categorizing the funds in specific ways. The MHSA cost report is attached to this response and will be available to anyone who requests to see it. Persons who have additional questions after the cost report review can set up time to discuss with staff.

11. NAMI has not been given requested information and therefore cannot state that Placer County Mental Health is doing well in its second year of the three year plan. In addition, if this county has approximately 2000 (5150's) in the year 2007 and the client base is approximately 1800 to 2000. We believe that for some reason this county is not "out of the woods yet" in providing proper services to the clients. NAMI-PC told you to expect more clients entering the system because of economics and the war.

    Answer: Placer agrees that the number of persons needing services in Placer continues to grow and that it is important to continue to find ways to provide resources to persons in the community as county services are being reduced.